PEAK
MANAGED CARE OPTION PLAN DESCRIPTION

A SUPPLEMENT
TO THE STATE OF MONTANA
EMPLOYEE BENEFITS SUMMARY PLAN DOCUMENT

This Supplement replaces corresponding medical benefit sections of the State of Montana Employee Benefits Summary Plan Document for members enrolled in the Managed Care Option (MCO) Plan administered by PEAK Health Plan.

For purposes of this Supplement:
"**Employer**" means State of Montana
"**Health Plan**" means PEAK Health Plan
"**PEAK Managed Care Option (MCO) Plan**" means the plan of benefits defined by this Supplement and applicable provisions of the Employer's Employee Benefits Summary Plan Document and current Schedule of Benefits.

Employer Contact:
Department of Administration
Health Care and Benefits Division
PO Box 200130
Helena MT 59620

Website: www.benefits.mt.gov
E-mail: benefitsquestions@mt.gov

1-800-287-8266
444-7462 in Helena

Health Plan Contact:
PEAK Customer Services at 1-866-368-7325 or visit their web site at
http://www.healthinfonetmt.com/PEAK/MainSearch.htm

Effective January 2008

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HOW TO OBTAIN BENEFITS

Payment of benefits under this PEAK MCO Plan will be made on the basis of your submission of required information to the PEAK Health Plan. You must also be eligible for benefits under the employer's employee benefit plan.

SECTION 1: OBTAINING BENEFITS

1.1 STEPS TO TAKE IN ADVANCE OF RECEIVING SERVICES

1. Make sure you have a current identification card from PEAK Health Plan (PEAK). Make sure it contains the correct identification number, name(s), dependent coverage information, and date(s) of birth. If you need services before you receive your card or have lost it, ask your provider to verify your coverage by calling PEAK or the employer at the numbers or location on the cover page. Replacement cards can also be ordered by calling PEAK customer service.

2. PEAK encourages (but does not require) each person to rely on a PEAK physician or mid-level practitioner of their choice to be their personal care provider (PCP). A PCP coordinates all or most of their patient's health care services, with the objective of increasing the quality, effectiveness and efficiency of this overall care. We recognize, however, that there also should be opportunity for PEAK enrollees to self-refer to different specialists for different needs. You are therefore permitted to self-refer to any PEAK physician or mid-level practitioner, according to your best judgment, without obligation to access the healthcare system through a single PCP. Moreover, full (in-network level) benefits are provided for covered services rendered by any and all PEAK network physicians and mid-level practitioners.

   You may search for network providers statewide or in your area by using the PEAK directory at: www.healthinfonetmt.com/PayorProviderSearch/PEAK/searchPEAK.asp. If you need care not available in the PEAK network, you may also search this website for PEAK extended network providers, whose covered services will qualify for the in-network level of benefits if delivered with referral by a PEAK in-network provider. These extended network providers have agreed to accept reduced allowable fees and not balance bill you for charges in excess of these fees. This saves both you and your employee benefits program money. Please note, you are not eligible for the in-network level of benefits if you self-refer to any extended network providers.

3. In advance of receiving services, know and optimize your benefits:

   a. Obtain pre-certification for inpatient hospital stays. All non-emergency inpatient hospital stays should be pre-certified (prior to admission) by calling the health plan to make sure the stay meets medical necessity requirements for inpatient benefits. All emergency admissions should be certified within 24 hours after admission, or at the first opportunity, to make sure any continued stay meets medical necessity criteria for inpatient benefits. The hospital will typically make this call to assure payment, but since you are responsible for all charges that are not for covered medical services, you should call as well for your own protection. You should also call to confirm, if needed, that the hospital is an in-network facility. *Pre-certification is especially critical for any inpatient facility admissions/stays for: transplants, treatment of mental illness or chemical dependency and rehabilitation services or recovery, as stated for these services in section 2.*

   b. Determine if you need prior authorization by the health plan for specific proposed medical procedures, equipment, or supplies. You must call the health plan and obtain prior authorization to receive benefits for:
      1) durable medical equipment expenses in excess of $1,000
      2) infertility treatment.
      3) obesity management (non-surgical).

   c. Identify services for which prior authorization is recommended. These include any services for which medical necessity may be in doubt. Any and all services are subject to medical review by the health plan, which can only be completed after services have been rendered and billed to the health plan. However, you may call PEAK customer service to obtain prior authorization of benefits for services that are new or outside standard medical practice (and which may be excluded as experimental), or that are only covered under some circumstances (as described in section 2).

d. Obtain the in-network level of benefits (the highest level of benefits described in this Supplement and the Schedule of Benefits) by:

1) obtaining covered medical services from a PEAK network provider listed on the PEAK search directory at the PEAK web site (see cover page); or

2) obtaining covered medical services from a PEAK extended network provider (also listed in the search directory) or out-of-network provider under the following circumstances:

a) with a referral from a PEAK physician or mid-level practitioner, or pre-certification by PEAK of any admission to an out-of-network hospital or prior authorization by PEAK, for transplant services; (*Referrals to Out-of-Network Providers are generally only made when circumstances preclude in-network services*); or

b) for treatment of an emergency medical condition or facility/ professional services for urgent care (care of an urgent medical condition). In the case of a medical emergency you are encouraged to obtain services from the closest appropriate provider. You will receive the in-network level of benefits for immediate treatment of an emergency medical condition by any provider, including an out-of-network provider. However, you will only receive the in-network level of benefits for any out-of-network follow up care (after the medical emergency has ended) if the above referral and PEAK authorization requirements are met.

Other covered services from an out-of-network provider will be covered at the out-of-network level of benefits (also described in the Schedule of Benefits). However, note that there is no coverage of medical services identified in 2.1.3 that are received out-of-network.

e. Determine if there are frequency, duration, or dollar limits on services you plan to receive so you can consider alternatives, if needed (see section 2 and the Schedule of Benefits).

f. If a PEAK physician or mid-level practitioner refers you to other than PEAK's in-network provider, request that consideration be given to a referral to a PEAK extended network provider. This will protect you against charges in excess of the health plan's allowable fee. You are responsible for paying excess charges (in addition to any applicable deductible, coinsurance, or copayment) unless the out-of-network provider has agreed to accept the allowable fee as full payment. See 1.1, 3, d for instructions on identifying PEAK extended network providers.

1.2 STEPS TO TAKE TO RECEIVE BENEFITS AND PAYMENT

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1. Present your identification card to the physician, hospital, or other health care provider when you or any covered dependents receive services, and pay any required co-payments.

2. Make sure the provider has your current identification number and address. If you change your address, notify the employer at the numbers or location on the cover page.

3. Most providers will file a claim for you; however, you are responsible for making sure a claim has been filed. A CLAIM MUST BE FILED WITH THE HEALTH PLAN WITHIN TWELVE MONTHS OF THE DATE OF SERVICE TO RECEIVE BENEFITS. You may need to complete a standard claim form if you use a provider who is neither a PEAK network provider, nor a PEAK extended network provider. A standard claim form should be available from the provider.

4. Payment will automatically be sent directly to PEAK network providers and to PEAK extended network providers who have agreed to accept allowable fees, as well as to out-of-network providers whose bills include an assignment of benefits from you. You will receive payment directly for services for which no assignment of benefits has been made. For both PEAK network and PEAK extended network providers, you will not be responsible for paying charges for covered medical services above allowable fees.

5. Respond to requests for information about accidents, pre-existing conditions, other insurance coverage, additional information for prior authorization or pre-certification or any other information requests from the health plan. Your

claim will not be adjudicated until and unless the required information is received within the time frame required by the health plan.

6. Monitor invoices from the provider and explanations of benefits from the health plan to make sure the health plan received and adjudicated a claim for services and that the provider received any payment due.

1.3 EXPLANATIONS OF BENEFITS (EOBs) & NOTIFICATION OF CLAIM APPEAL RIGHTS

Check the EOB's from the health plan to determine if you have received the benefits described in this Managed Care Supplement and to determine what fees you owe the provider (deductible, copayments not paid at the time of service, coinsurance, charges for uncovered services, and charges in excess of allowable fees when using providers who are not in the MCO Plan network.

If a claim is denied in whole or in part, the claimant will receive written notice of the adverse benefit determination. A claim Explanation of Benefits (EOB) will be provided by the health plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific MCO Plan provision(s) or rule(s) upon which the claim decision was based which resulted in the denial or partial denial;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the claimant's right to appeal the adverse benefit determination for a full and fair review.

If a claimant does not understand the reason for any adverse benefit determination, he or she should contact the health plan at the address or telephone number shown on the EOB. See the Employer's Summary Plan Document for appeal procedures.

1.4 SELF-AUDIT AWARD

To receive a self-audit reward of up to $1,000, check bills from your medical providers to make sure you have not been double billed for services or billed for services you haven't received.

You can receive an award of 50% of identified over-charges up to $1,000 as follows:

a. The over-charges may not have already been detected by the health plan or reported by the provider.
b. The over charges must be $50 or more, and
c. The over-charges must be within allowable fees for covered medical expenses.

To receive a self-audit award, take the following steps:

a. Notify the health plan of the error before it is detected by the plan or provider
b. Contact the provider to verify the error and determine or work out a correct billing
c. Have copies of the corrected billing sent to the health plan for verification, claims adjustment and calculation of the self-audit award.

SECTION 2: PLAN BENEFITS

2.1 COVERED MEDICAL EXPENSES AND SERVICES, GENERALLY

2.1.0 COVERED MEDICAL EXPENSE

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Covered medical expenses of the PEAK MCO Plan are:

a. expenses within allowable fees (you are responsible for charges in excess of allowable fees if you use a provider other than a PEAK network provider or a PEAK extended network provider);

b. expenses within the specified benefit limitations contained in this Supplement and the current Schedule of Benefits, and which meet other requirements of the Employer's Summary Plan Document (such as applicable waiting periods); and

c. expenses for covered medical services, defined next.

2.1.1 COVERED MEDICAL SERVICES

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Covered medical services are services, procedures, and supplies:

a. listed in this Supplement as covered medical services, and not specified as exclusions in this Supplement or in the Schedule of Benefits.

b. determined by the health plan to be medically necessary for the diagnosis or treatment of:
   1) injury;
   2) illness;
   3) maternity care; or
   4) are preventive services specified in this section.

c. provided in accordance with the terms of this MCO Plan including any prior authorization requirements and time limits or service limits.

d. provided to a member by a licensed provider; and

e. provided and coded in accordance with applicable medical policy and industry standards.

Covered medical expenses are paid or credited to the member's deductible, copayment and coinsurance obligations for the applicable level of benefits as described below.

2.1.2 IN-NETWORK LEVEL OF BENEFITS

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You receive the in-network level of benefits (described the Schedule of Benefits) for covered medical services that are:

a. provided by a PEAK in-network provider;
b. treatment of an emergency medical condition or facility/professional services for urgent care (care of an urgent medical condition) by any provider;
c. other out-of-network care with prior referral by a PEAK physician or mid-level practitioner plus pre-certification of any out-of-network hospital admission, and prior authorization of transplant services.

You will be responsible for any deductible, copayment and coinsurance amounts, which the current Schedule of Benefits specifies for the in-network level of benefits. See 2.2 – 2.110 and 2.12 for any special requirements for receiving the in-network level of benefits for particular covered medical services or services with limited coverage.

2.1.3 OUT-OF-NETWORK LEVEL OF BENEFITS

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You will receive the reduced out-of-network level of benefits (described in the Schedule of Benefits) for all other covered medical services obtained out-of-network with some exceptions. There are no out-of-network benefits for the following services (although in-network benefits may apply when provided out-of-network under some circumstances as described above):

a. organ transplant services;
b. infertility treatment; and
c obesity management (non-surgical).

(Note that b. & c. require prior authorization for any benefits.)

For covered medical services eligible for the out-of-network level of benefits, you will be responsible for any applicable copayment, deductible, and coinsurance amounts described in the current Schedule of Benefits. You will also be responsible for any charges in excess of the health plan's allowable fee by out-of-network providers who do not accept the health plan's allowable fees as full compensation as well as any applicable out-of-network differential.

2.2 DIAGNOSTIC/LAB

2.2.0 DIAGNOSTIC / LABORATORY SERVICES

1. Coverage includes radiology, laboratory and tissue diagnostic examinations, and diagnostic machine tests (such as EKGs) made for the purpose of diagnosing accident or illness when hospital confinement is not required and benefits are not provided elsewhere in this Supplement.

2. Radiology and laboratory benefits shall not be provided for the following:

   a. dental examinations or treatments, except for dental x-rays resulting from injuries sustained in an accident (covered under 2.12.3);
   b. visual examinations; and
   c. premarital examinations and routine physical checkups, including examinations made as a requirement of employment or governmental authority, except as provided in 2.8.0.

2.3 EMERGENCY

2.3.0 AMBULANCE

Coverage only includes emergency ground or emergency air transportation to the nearest hospital or medical facility that is equipped to furnish the services, unless otherwise approved by the health plan. The emergency transportation must be medically necessary. The medical necessity is established when the patient's condition is such that other means of transportation would endanger the health of the member. Transportation is not covered if not medically necessary. Please see the current Schedule of Benefits for the ambulance transportation copayment.

2.3.1 EMERGENCY CARE

Coverage includes health care for an emergency medical condition with acute symptoms that would reasonably cause a member to believe that the absence of medical attention would place the member's health in serious jeopardy, cause serious impairment to bodily functions, or cause serious dysfunction of a bodily organ or part.

The emergency room copayment (as identified in the Schedule of Benefits) only includes the facility charges. Any lab fees, diagnostic fees or professional services charges are subject to deductible and coinsurance.

SPECIAL REQUIREMENT TO RECEIVE THE IN-NETWORK LEVEL OF BENEFITS FOR OUT-OF-NETWORK SERVICES

The in-network level of benefits is provided for out-of-network emergency services immediately required to diagnose and treat an emergency medical condition at the nearest appropriate medical facility without prior referral by a PEAK physician or mid-level practitioner.

If an emergency medical condition is determined to exist that requires hospital admission or any follow-up services, you must notify the health plan within 24 hours of (or the next working day after) the initial emergency care so the health plan can coordinate the subsequent follow-up care and assure continued in-network benefits. If you are incapable of calling or having a representative call the health plan within 24 hours (or on the next working day), you should contact the health plan as soon as medically possible. Once medical stabilization is achieved, PEAK may require transfer to a PEAK network hospital for the in-network level of benefits to continue.

2.4 HOSPITAL

2.4.0 INPATIENT HOSPITAL CARE

Pre-certification of all non-emergency hospital admissions is strongly recommended. See 2.3.1 for emergency admissions.

Inpatient hospital care coverage includes, but is not limited to: room and board at the semi-private room rate, general nursing care; special diets; use of operating room and related facilities; use of intensive

care units and services; radiology, laboratory, and other diagnostic tests; drugs, medications, biologicals, anesthesia, and oxygen services; physical, radiation, and inhalation therapy; psychotherapy; administration of whole blood and blood plasma; short-term rehabilitation therapy services; and medical detoxification when the inpatient stay is certified as medically necessary by the health plan.

2.4.1 OUTPATIENT HOSPITAL SERVICES

Hospital services and supplies described in 2.4.0 are covered if a member is treated at a licensed hospital, but not admitted for bed patient care. Charges for observation beds/rooms are covered when medically necessary and in accordance with medical policy for services of less than 24 hours and for charges not exceeding the room rate that would be charged for an inpatient stay of one day. See 2.10.0 for information on outpatient surgical services.

2.5 MATERNITY, GYNECOLOGY AND NEWBORN CARE

2.5.0 OBSTETRICS AND GYNECOLOGY/GYN

Coverage includes medically necessary obstetrical and gynecological services.

If you enroll in the employer's prenatal wellness program within the first trimester of pregnancy, the following will be waived:

1. Copayments for in-network prenatal and post-natal office visits and deductible and coinsurance on routine labs (that have not already been assessed before enrollment); and

2. Deductible and coinsurance on in-network professional service charges for the delivery.

Contact the employer for information on the employer's prenatal wellness program and how to enroll. Without timely enrollment in the prenatal wellness program, charges are subject to deductible and coinsurance as described in the current Schedule of Benefits.

Ultrasounds will be subject to standard deductible and coinsurance with the first ultrasound exempted if the member enrolls in the pre-natal wellness program as described above.

2.5.1 FACILITY OBSTETRICAL DELIVERY CARE AND SERVICES

Coverage includes facility obstetrical delivery care and services for covered female members including services of a birthing center. A minimum 48-hour inpatient facility stay is allowed for a normal delivery, and a minimum 96-hour inpatient facility stay for a cesarean section delivery, unless otherwise agreed and deemed appropriate by the member and attending professional provider.

2.5.2 ROUTINE NEWBORN CARE

Coverage includes the initial routine care of a newborn at birth provided by a physician, standby care provided by a pediatrician at cesarean section, and facility nursery care of newborn infants. In-network facility and professional service charges are exempt from deductible.

2.6 MISCELLANEOUS

2.6.0 CONGENITAL ANOMALY

Coverage includes the treatment only of medically diagnosed congenital defects and birth abnormalities.

2.6.1 DIALYSIS

Coverage is provided for renal disease, including the equipment, training, and medical supplies required for effective home dialysis.

2.6.2 HOME INFUSION THERAPY

Coverage hospital includes, but is not limited to: antibiotic therapy, enteral nutrition, total parenteral nutrition, pain management, and specialized disease state therapy.

2.6.3 INBORN ERRORS OF METABOLISM (including PKU)

Coverage includes the treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism, and for which medically standard

methods of diagnosis, treatment, and monitoring exist. Treatment includes diagnosing, monitoring, and controlling the disorders by nutritional and medical assessment including, but not limited to: clinical services, biochemical analysis, medical supplies, corrective lenses for conditions related to the inborn error of metabolism, nutritional management, and medical foods used in treatment to compensate for the metabolic abnormality and to maintain adequate nutritional status.

In-network supplies, including medical foods, are exempt from deductible.

2.6.4 INJECTIBLE BENEFIT

Coverage includes injectible medications administered at the provider's office or facility, when not able to be self-injected including, but not limited to contraception, pain control, and administration of antibiotics.

Injectibles billed without an office visit are exempt from deductible and only subject to coinsurance.

2.7 PHYSICIAN

2.7.0 INPATIENT PROVIDER CARE

Pre-certification of all non-emergency hospital admissions is strongly recommended. See 2.3.1 for emergency admissions.

Coverage includes health care services performed, prescribed, or supervised by a professional provider, including diagnostic, therapeutic, medical, surgical, preventive, referral, and consultative health care services.

2.7.1 OUTPATIENT OFFICE VISIT SERVICES

Coverage includes health care services provided by a physician or mid-level practitioner working in a physician's office or clinic, or by other office/clinic staff members under physician direction. This includes, but is not limited to: diagnostic, treatment, laboratory, x-ray, radiation and referral services.

The in-network office visit copayment only covers the office visit allowable fee. Any laboratory, x-ray, radiation, tests, or other ancillary procedures are subject to deductible and coinsurance unless covered under the preventive benefits described in 2.8.0 and 2.8.1 below.

2.8 PREVENTIVE

2.8.0 ADULT PREVENTIVE SERVICES

Coverage includes the following age and gender appropriate periodic tests and services:

1. Nineteen (19) years through thirty nine (39) years of age:

    a. One physical exam every two years, including history, screening for high-risk behavior, urinalysis, Hemoglobin OR Hematocrit, basic metabolic panel and cholesterol and lipid screening (covered preventive labs are included in the in-network office visit copayment);

    b. For female members, the physical exam also includes a gynecological exam and pap test, which are covered annually, on off years as well (covered preventive labs are included in in-network office visit copayment);

    c. For female members, one baseline mammogram between thirty five (35) and thirty nine (39) years of age; for female members with a documented family history of disease risk, annual mammograms when prior authorized (paid at 100% if in-network; see Schedule of Benefits for out-of-network benefit).

2. Forty (40) years and older:

    a. One physical exam every year, including history, screening for high-risk behavior, urinalysis, Hemoglobin OR Hematocrit, basic metabolic panel, cholesterol and lipid screening and stool occult blood colorectal screening (covered preventive labs are included in office visit copayment);

    b. For female members, the physical exam also includes a gynecological exam and pap test (included in office visit copayment);

    c. For male members, the physical exam also includes PSA screening (included in office visit copayment);

d. One ECG/EKG per lifetime (subject to coinsurance & deductible);

e. For female members, one mammogram every year (paid at 100% in-network; see Schedule of Benefits for out-of-network benefit).

f. Beginning at age 50, a flexible sigmoidoscopy and double-contrast barium enema every five years; a colonoscopy every ten years (subject to coinsurance & deductible);

g. Bone density scan every five years (subject to coinsurance & deductible) for female members age 60 and over and male members age 70 and over.

3. **Immunizations & allergy shots:** Adult allergy shots and immunizations recommended by the Centers for Disease Control Immunization Guidelines are covered excluding immunizations recommended because of increased risk due to type of employment or travel, such as, but not limited to: malaria, yellow fever, hepatitis B, and tuberculosis (included in in-network office visit copayment). *In-network immunizations and allergy shots billed without an office visit are exempt from deductible and only subject to coinsurance up to a $10 maximum.*

2.8.1 WELL CHILD BENEFITS

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Well-child care benefits include:

1. a history, physical examination, developmental assessment, and anticipatory guidance by a physician, as those terms are defined in 33-33-303 MCA, and laboratory tests according to the schedule of visits adopted under the early and periodic screening, diagnosis, and treatment services program provided for in MCA 53-6-101 from birth through age seven (7). Visits are covered at the following approximate ages:

    - A visit for any newborn who did not receive a newborn exam in a hospital or birthing facility or who was discharged from a hospital in less than 36 hours;
    - 1 month;
    - 2 months;
    - 4 months;
    - 6 months;
    - 9 months;
    - 12 months;
    - 15 months;
    - 18 months;
    - 24 months;
    - and one per year thereafter, through the child's seventh (7th) year of age; (covered preventive labs are included in office visit copayment)

2. An age and gender appropriate physical examination every two years from age 8 through age eighteen (18) including a gynecological examination and pap test for pubescent girls at the discretion of the physician (covered preventive labs are included in office visit copayment); and

3. Routine immunizations (according to the schedule of immunizations recommended by the Immunization Practices Advisory Committee of the U.S. Department of Health and Human Services) and allergy shots.

In-network allergy shots and covered laboratory tests and immunizations are included in the office visit copayment. In-network immunizations and allergy shots received without an office visit are exempt from deductible and only subject to coinsurance up to a $10 maximum.

2.9 SEVERE MENTAL ILLNESS

2.9.0 SEVERE MENTAL ILLNESS

. . . . . .

Pre-certification of all non-emergency hospital admissions is strongly recommended. See 2.3.1 for emergency admissions.

Coverage includes medically necessary care and treatment of severe mental illness as defined in 33-22-706 MCA.

1. Schizophrenia.
2. Schizo-affective disorder.
3. Bipolar disorder.
4. Major depression.
5. Panic disorder.
6. Obsessive-compulsive disorder.
7. Autism.

2.10 SURGERY

2.10.0 SURGICAL CENTER AND OUTPATIENT HOSPITAL SURGERY SERVICES

Coverage includes surgical center or outpatient hospital services and supplies and professional services furnished in connection with a covered surgical procedure performed in the center, provided the center is licensed or certified for Medicare by the state in which it is located. See 2.4.0 and 2.7.0 for coverage of inpatient surgery, and see information on specific surgeries below.

2.10.1 MASTECTOMY

Coverage is provided for mastectomies due to malignancy, and as a result of disease, illness, or injury.

2.10.2 RECONSTRUCTIVE BREAST SURGERY

Coverage provides reconstructive surgery after a mastectomy, which resulted from disease, illness, or injury.

Coverage is provided for:

a. reconstruction of the breast on which the mastectomy was performed;
b. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
c. prostheses and treatment of any physical complications resulting from the mastectomy, including lymphedemas.

2.10.3 ORAL SURGERY

Coverage includes non-cosmetic surgical treatment for the excision of lesions of the oral cavity, tongue, cheek, and maxillary/mandibular fracture, or for the treatment of degenerative joint disease that is associated with rheumatoid arthritis or osteoarthritis of the TMJ. Surgical treatment of TMJ pain, dysfunction or disease is covered when medically necessary. Non-surgical treatment is not covered.

ORTHOGNATHIC SURGERY (RECONSTRUCTIVE JAW SURGERY)

Coverage is provided only for the treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration of the member's physical condition because of inadequate nutrition.

Dental appliances, splints, orthodontia, or other services associated with covered jaw surgery are considered dental services and are not covered under the medical benefit.

2.10.4 RECONSTRUCTIVE SURGERY

Coverage is provided in order to restore bodily function or correct deformity resulting from a disease, trauma, or congenital or developmental abnormality. Coverage includes any consequences or complications that may arise from a covered surgery or related service.

2.11 URGENT CARE

2.11.0URGENT CARE

Coverage includes care for an acute illness or injury that requires immediate treatment (such as high fever; ear, nose, and throat infections; and minor sprains and lacerations).

The office visit copayment (specified in the Schedule of Benefits) applies to allowable facility and professional fees for urgent care from any licensed provider. If out-of-network follow up care is necessary because you are outside the PEAK service area, call PEAK at 1-888-256-6556 for prior authorization to continue the in-network level of benefits for facility and professional care.

Any lab, x-ray, radiation, tests or other diagnostic services are subject to deductible and coinsurance.

2.12 SERVICES WITH LIMITED COVERAGE

The following are health care services and supplies that are covered as described in 2.1 – 2.11, but with special limitations.

Some of these services have no out-of-network level of benefits, as specified next (and as listed in 2.1.3). They are only covered when provided by a PEAK physician or mid-level practitioner, or with a PEAK physician's or mid-level practitioner's referral. Some services require prior authorization by the health plan

(in advance of the service) for any benefits (either in-network or out-of-network). Some have dollar or service limits, or require a physician's order.

2.12.1 CHEMICAL DEPENDENCY TREATMENT

Pre-certification of all non-emergency hospital admissions is strongly recommended. See 2.3.1 for emergency admissions.

Coverage is provided for inpatient and outpatient treatment for alcoholism and drug addiction (excluding costs for medical detoxification, which is covered under 2.4.0). Coverage is limited to a maximum combined (inpatient and outpatient) amount for a 12-month period and to a lifetime maximum inpatient amount (see Schedule of Benefits). After that, a small annual benefit for inpatient and outpatient treatment may be available (see Schedule of Benefits).

2.12.2 CHIROPRACTIC SERVICES

Please refer to the Schedule of Benefits for visit limitations. The in-network office visit copayment covers allowable professional fees. Deductible and coinsurance apply to x-rays, ultrasounds, and other ancillary procedures.

2.12.3 DENTAL SERVICES FOR ACCIDENTAL INJURY

Coverage is provided for the treatment of accidental dental injury only. It is limited to the restorative services and supplies necessary for the treatment of a fractured jaw or other accidental injury to sound natural teeth completed within twelve (12) months after the date of the accidental injury.

Services for the treatment of accidental injury to teeth caused by biting or chewing are exclusions of this provision (but may be covered by an employer dental plan).

2.12.4 DURABLE MEDICAL EQUIPMENT (DME), PROSTHETICS, OXYGEN SUPPLIES AND FOOT ORTHOTICS

Prior authorization is required for DME expenses in excess of $1,000. Coinsurance does not count toward annual out of pocket maximum (coinsurance maximum).

Coverage is provided for the following services and supplies for therapeutic use in a member's home:

a. rental (up to purchase price) or purchase, which ever meets the therapeutic purpose for less, of a hospital-type bed, wheelchair, walker or other durable medical equipment and repair of purchased equipment (provided the equipment is designed for prolonged use, serves a specific therapeutic purpose in the treatment of an illness or injury, is primarily and customarily used for a medical purpose, is appropriate for use in the home, and is not generally useful to a person in the absence of illness or injury). *The health plan will be responsible for determining rental versus purchase agreements. Requests for computerized and "deluxe" equipment, like motor-driven wheelchairs, are reviewed on an individual basis. The health plan will have the right to decide when standard equipment is adequate. Coverage does not include maintenance, replacement due to loss, or duplication. Replacement can occur when equipment or prosthetics are no longer repairable or when DME is outgrown.*

b. foot orthotics (limited to a dollar amount per foot per year specified in the current Schedule of Benefits , and excluding coverage of orthotics for the sole purpose of treating sports-related activities);

c. oxygen services and supplies; and

d. prosthetic appliances, including the purchase and fitting of breast prostheses and the purchase and fitting of artificial limbs, larynx, eyes, other prosthetic appliances or permanent internally implanted devices that are not experimental. Repair, maintenance, replace-ment due to loss, and duplication are not covered. Replacement can occur when the item is no longer repairable.

2.12.5 DISEASE PROCESS EDUCATION & DIETARY NUTRITIONAL COUNSELING

Coverage is for disease management educational programs including medically necessary dietary or nutritional counseling when referred by a PEAK in-network physician or mid-level practitioner. The program must be a certified educational program administered by an in-network facility or in-network professional provider. Covered programs/clinics include, but are not limited to: diabetes, multiple sclerosis, respiratory, polio, and cardiac clinics. Educational services are otherwise excluded. See the current Schedule of Benefits for benefit maximum.

2.12.6 HOME HEALTH SERVICES

Coverage includes the following services and supplies furnished by a licensed home health agency for the care of a member in accordance with a physician's written home health care plan:

a. part-time or intermittent skilled care provided by a registered nurse or licensed practical/ vocational nurse;

b. physical, occupational, respiratory, and home infusion therapies (up to the home health visit maximum described below and in the current Schedule of Benefits);

c. medical supplies, prescribed medications, and lab services provided at home; and

d. part-time or intermittent home health aid services required to allow the member to be treated at home.

Home health services are limited to the number of visits per benefit year specified in the current Schedule of Benefits, where a day with any home health service is counted toward the maximum home health services.

The following services are not covered:

a. services and supplies not part of the home health care plan;
b. domestic or housekeeping services such as Meals on Wheels;
c. services for mental or nervous conditions;
d. transportation; and
e. disposable supplies self-administered in the home (gauze, bandages, etc.) unless covered elsewhere and DME and prostheses, which are covered elsewhere.

2.12.7 HOSPICE SERVICES

Hospice care is covered for members who are diagnosed as having a terminal illness with a life expectancy of six months or less when ordered by a physician. The following hospice services are covered:

a. Facility expenses of a hospice facility, hospital, or skilled nursing facility for board, room, and other services and supplies furnished to a person while inpatient for pain control and other acute and chronic symptom management. Expenses for a private room are covered only up to the regular daily expense for a semi-private room unless a private room is medically necessary or a semi-private room is unavailable; and

b. Hospice expenses for:
   1) nursing care provided by a registered nurse or licensed practical nurse, and services of a home health aide;
   2) medical social services provided under the direction of a physician;
   3) psychological and dietary counseling;
   4) consultation or case and management services;
   5) medically necessary physical and occupational therapy;
   6) medical supplies, drugs, and medicines prescribed by a physician; and
   7) expenses for consultant or case and disease management services, or physical or occupational therapy by health care providers who are not employees of the hospice - but only when the hospice retains responsibility for the care.

2.12.8 INFERTILITY TREATMENT

Prior authorization is required for benefits. No out-of-network level of benefits is available.

Benefits include diagnostic and evaluation services to determine if treatment for infertility is necessary. Follow-up treatment is limited to members who have been diagnosed as biologically infertile in accordance with accepted medical practice. Artificial insemination attempts per member per lifetime are limited to the number specified in the current Schedule of Benefits. Medically indicated fertility drugs that are authorized by the health plan must be obtained through the employer's prescription drug plan under the terms of that plan. Infertility benefits do not include in-vitro fertilization, and are not covered for members who have undergone a voluntary sterilization procedure.

2.12.9 MENTAL ILLNESS

Prior authorization of all non-emergency hospital admissions is strongly recommended. See 2.3.1 for emergency admission.

Coverage is provided for medically necessary inpatient and outpatient treatment of mental illness. Inpatient services are limited to the maximum number of days specified in the current Schedule of Benefits. Two partial hospitalization days can be received in lieu of one inpatient day. Outpatient

benefits are limited to the maximum number of visits specified in the current Schedule of Benefits. There are no inpatient or outpatient maximums for severe mental illness defined in 33-22-706, MCA.

Covered medical services do not include treatment of the following conditions:

a. developmental and learning disorders;
b. speech disorders;
c. psychoactive substance abuse disorders;
d. eating disorders (except bulimia and anorexia nervosa);
e. impulse control conduct disorders (except intermittent explosive disorder and trichotillomania);
f. mental retardation; or
g. inpatient confinement for environmental change.

2.12.10 OBESITY MANAGEMENT

Prior authorization is required for benefits. No out-of-network level of benefits is available.

Coverage includes non-surgical treatment for reducing or controlling weight under a prior-authorized treatment plan. The member must meet the definition of morbid obesity to begin receiving benefits, and must make timely progressive weight loss, as defined in the prior authorization, for benefit continuation. Medically indicated drugs that are authorized by the health plan must be obtained through the employer's prescription drug plan under the terms of that plan.

Non-surgical treatment includes the following services:

a. Initial evaluation and history;
b. Follow-up monthly visits;
c. X-ray and laboratory tests;
d. Other miscellaneous tests such as ECG, stress test, tread mill;
e. Continued care based upon medical necessity and independent medical review.

Bariatric and other surgeries to reduce weight, dietary supplements, and exercise programs are not included in this benefit.

2.12.11 REHABILITATIVE SERVICES

Please refer to your current Schedule of Benefits for inpatient and outpatient maximums.

Coverage includes pulmonary, cardiac, respiratory, physical, and occupational therapy that is ordered by a licensed physician and determined to show proven gain in function. For therapies to be eligible for coverage, the member must meet one or more of the following criteria:

a. has suffered an acute injury or serious illness which debilitates muscles or speech, or hinders the activities of daily living; or

b. is receiving treatment for medically diagnosed congenital defects or birth abnormalities; or

c. is suffering an exacerbation of an illness/injury, causing further debilitation.

Coverage is provided for services of a licensed speech therapist for speech therapy, also called speech pathology, and audio diagnostic testing services for diagnosis and treatment of speech and language disorders when all of the following criteria are met:

a. There is a documented condition that can be expected to improve with therapy within a reasonable time.
b. Improvement would not normally be expected to occur without intervention.
c. Treatment is rendered for a condition that is the direct result of a diagnosed neurological muscular or structural abnormality affecting the organs of speech.
d. Therapy has been prescribed by the speech language pathologist or physician and includes a written treatment plan with estimated length of time for therapy, along with a statement certifying all conditions are met.

Speech therapy is not covered if:

a. treatment is for stuttering:
b. treatment is for behavioral or learning disorders.

2.12.12 SKILLED NURSING FACILITY CARE

Please refer to current Schedule of Benefits for maximum days covered.

Coverage is provided for medically necessary care by a licensed skilled nursing facility, or part of an institution that offers skilled nursing care.

2.12.13 TRANSPLANTS

No out-of-network level of benefits is available. Benefits (the in-network level) are only available through the designated transplant network or when prior authorized by PEAK due to unavailability of a PEAK network or extended network provider. Prior authorization or pre-certification is strongly recommended.

The health plan has designated certain hospitals to perform covered transplants. These hospitals have been selected for their experience in performing transplants and no benefits are available from other hospitals (except under rare circumstances approved in advance by the health plan). In some instances, the designated hospital may not be located in the health plan's service area, therefore requiring travel. Contact the health plan for a list of designated transplant facilities. Please refer to the current Schedule of Benefits for benefit maximums.

a. Covered Transplant Services

Coverage includes the following for covered transplants:

1) evaluation;
2) pre-transplant care;
3) transplant and certain specific donor-related services; and
4) follow-up treatment.
5) travel reimbursement benefits up to the maximum in the Schedule of Benefits (subject to Federal guidelines) during the dates for which a transplant contract is in effect, or up to one year after the date of the transplant, whichever is longer.

b. Covered Transplants

The following human organ/ tissue transplants are covered:

1) corneal
2) heart
3) kidney
4) liver
5) lung
6) pancreas

Bone marrow transplants are covered, when medically necessary, under the following circumstances:

1) Allogenic and Syngeneic Bone Marrow Transplants (requires HLA typing match on at least five out of six loci)

a) acute lymphocytic leukemia and non--acute lymphocytic leukemia
b) chronic melogenous leukemia
c) aplastic anemia
d) Franconi's Anemia
e) infantile malignant osteopertrosis
f) large-cell lymphoma
g) lymphoma
h) Severe Combined Immudeficiency Disease (SCIDS)
i) Wiscott Aldrich Syndrome

2). Autologous Bone Marrow Transplants

a) acute lymphocytic leukemia and non--acute lymphocytic
b) leukemia
c) Burkitts Lymphoma
d) large-cell lymphoma
e) non-Hodgkin's lymphoma
f) Hodgkin's Disease
g) neuroblastoma

3). Stem cell transplants in conjunction with high-dose chemotherapy are covered, when medically necessary. Prior authorization is recommended (a retrospective review will be done if services are not prior authorized). High-dose chemotherapy with either allogenic or autologous stem-cell transplant will be considered on a case by case basis.

c. Donor Benefits

Donor services and supplies will not be covered if provided to an enrolled donor when the recipient is not enrolled in the PEAK managed care option plan or is not eligible for transplant benefits. The exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.

d. No Coverage for the Following:

1) Services or expenses related to the transplantation of animal or artificial organs.

2) Transplants that are not currently approved under Medicare transplant guidelines.

3) Charges that are not routinely made to all patients receiving similar human transplants.

4) Benefits for a human transplant donor who has coverage for services related to the organ or tissue donation elsewhere. If the donor does not have coverage elsewhere, and the recipient is a member, then the donor will be covered under this PEAK Managed Care Plan, but only for health services related to the organ or tissue donation.

5) Kidney transplants that are first covered by Medicare.

6) Experimental or investigational procedures.

2.13 PLAN EXCLUSIONS

. . . . . .

The following are exclusions of this MCO Plan:

2.13.1 NON-COVERED SERVICES

Exclusions include health care services and supplies that are not listed as covered medical services even if provided by a licensed provider.

2.13.2 SERVICES WHICH ARE NOT MEDICALLY NECESSARY

2.13.3 NON-AUTHORIZED SERVICES

Exclusions include services not performed, arranged, authorized, or approved as specified in this Supplement.

2.13.4 PRESCRIPTION DRUGS

Exclusions include outpatient prescription drugs, which are covered by a separate prescription drug plan.

2.13.5 PRE-EXISTING CONDITIONS

Pre-existing conditions are excluded for up to one year from a member's coverage effective date. However, the period of exclusion may be reduced by creditable coverage (see the Employer's Summary Plan Document).

2.13.6 HEARING AID SERVICES

Exclusions include all services and supplies related to the purchase, examination, or fitting of hearing aids; supplies; and tinnitus maskers.

2.13.7 COMPLICATIONS FROM INELIGIBLE PROCEDURE

Exclusions include surgery and other services and supplies related to (or required to treat) complications arising from any procedure ineligible for coverage under this Supplement.

2.13.8 ELECTIVE, COSMETIC, AND VOLUNTARY HEALTH SERVICES

Except as specifically provided in this Supplement, exclusions include all services related to voluntary personal health improvement, cosmetic, or other elective health care including, but not limited to:

a. Surgery and any related services for the sole intent to improve appearance.

b. Services and supplies for cosmetic purposes, including the restoration of hair, appearance of skin, and/or body shape.

c. Personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, or physical fitness equipment.

d. Lifestyle improvements, such as physical fitness programs.

e. Services and/or memberships provided through facilities including, but not limited to: health clubs, fitness centers, or spas.

f. Dietary regimen supplements and/or exercise programs for the controlling or reduction of weight, except the limited obesity treatment benefit (described in 2.12.10).

g. Dietary supplements, except medical foods required for the treatment of inborn errors of metabolism (described in 2.6.3).

h. Procedures, services, drugs, and supplies related to elective abortions, except when the pregnancy is the result of an act of rape or incest.

i. Treatment leading to (or in connection with) sexual reassignment including, but not limited to: surgery and mental health counseling.

j. Services and supplies for (or related to) conception by artificial means, except as provided in 2.12.8.

k. Services and supplies needed to reverse a sterilization procedure, including tubal ligations and vasectomies.

1. Treatment of sexual dysfunction.

m. Pastoral, financial, or legal counseling.

n. Counseling services for adolescent behavior problems, learning delays, self discovery and improvement, and family and marital problems.

o. All services related to routine, non-medically necessary foot care including, but not limited to: the treatment or removal of corns, calluses, or nails; hypertrophy; hyperplasia of skin or subcutaneous tissues; cutting or trimming of nails; treatment of weak, strained, or flat feet; fallen arches; orthotic appliances, lifts, and orthopedic shoes (except the foot orthotic benefit provided in 2.12.4); padding and strapping; and fabrication.

p. Physical examinations and other services required for obtaining or maintaining employment, insurance, or government licensing, unless they are a portion of an annual physical assessment covered as an adult preventive service (as defined in 2.8.0).

q. School, sports, and camp physicals, unless they are part of an annual physical assessment covered as preventive services (as defined in 2.8.0 or 2.8.1).

r. Over-the-counter supplies including, but not limited to: bandages, splints, and medications, with the exception of foods for inborn errors of metabolism.

s. Any device for the sole purpose of enhancing sports-related activities.

t. Immunizations for foreign travel.

u. Education or tutoring services, except as provided in 2.12.5.

2.13.9 NURSING HOME AND RELATED CONVALESCENT CARE

Except as specifically provided in this Supplement, exclusions include:

a. Confinement in a skilled nursing facility, convalescent hospital, other facility or that part of any such facility used for:
   1) convalescent, custodial, or rest care;
   2) mental illness or chemical de-pendency care; or
   3) training or schooling.

b. Services or articles for custodial, convalescent, or maintenance care; domiciliary care; rest care; or care designed primarily to assist in the activities of daily living.

c. Long-term care services.

2.13.10 EXPERIMENTAL PROCEDURES

Exclusions include experimental procedures and/or medical treatments, procedures, drugs, devices, or biologics that are experimental, investigational, or used for research.

2.13.11 NON-STANDARD, OR SELF PRESCRIBED SERVICES AND SUPPLIES

Except as specifically provided in this Supplement, plan exclusions include all services for non-standard or self-prescribed therapies. Exclusions include, but are not limited to:

a. orthomolecular therapy, including nutrients, vitamins, and food supplements;
b. hypnotism, hypnotherapy, or hypnotic anesthesia;
c. acupuncture or acupressure;
d. stress management;
e. biofeedback;
f. naturopathy;
g. homeopathy;
h chelation therapy (except for mineral or metal poisoning);
i. massage or massage therapy; and
j. rolfing

2.13.12 INJURY OR SICKNESS RELATED TO ILLEGAL ACTIVITIES

Exclusions include the care and treatment of injuries or sickness due to the commission of (or attempt to commit) a felony act, or engaging in an illegal act or occupation.

2.13.13 INJURY OR SICKNESS RELATED TO A RIOT

Exclusions include the care and treatment of injuries or sickness due to voluntary participation in a riot.

2.13.14 LEGALLY-ORDERED SERVICES

Exclusions include services required by a court order, or as a condition of parole or probation.

2.13.15 ADMINISTRATIVE CHARGES

Exclusions include charges for missed appointments or other administrative sanctions.

2.13.16 INJURIES OR SICKNESS RELATED TO MILITARY SERVICE

Exclusions include services for (or related to) any sickness or injury suffered as a result of (or while in) military service.

2.13.17 SERVICES INCURRED OUTSIDE THE COVERAGE PERIOD

Exclusions include services incurred outside the coverage period including:

a. while the member is not covered;
b. prior to the effective date of coverage for a member; and
c. after a member's termination of coverage and after any extension of benefits or continuation of coverage as specified in the Employer's Summary Plan Document.

2.13.18 TRAVEL

Travel is excluded, except transportation of the patient in an emergency to the nearest facility qualified to treat the injury or disease, or as otherwise provided in the ambulance benefit (2.3.0) or transplant benefit (2.12.13), and approved by the health plan.

2.13.19 CERTAIN PRIVATE ROOM CHARGES

Exclusions include private room accommodations to the extent charges are in excess of the institution's most common semi-private room charge, unless a private room is deemed medically necessary by the health plan.

2.13.20 DUPLICATE SERVICES OR SERVICES COVERED UNDER ANOTHER BENEFIT PLAN

Except as specifically provided in this Supplement, and subject to the coordination of benefits section of the Employer's Summary Plan Document, all services covered by another benefit plan are excluded including, but not limited to:

a. Government-Covered Services and Supplies

Exclusions include services and supplies to the extent they are covered by any governmental law, regulation, or program (such as Medicare, Medicaid, and Champus), subject to federal and state laws or regulations.

Under certain circumstances, the law allows certain governmental agencies to recover expenses for services rendered to you from your PEAK managed care option plan. When such a circumstance occurs, you will receive an EOB.

b. Workers' Compensation-Covered Services

Exclusions include services for injuries or diseases for which benefits are (or should be) provided pursuant to state workers' compensation laws.

This exclusion applies to all services and supplies provided to treat such illness or injury even though one or more of the following apply:

1) Coverage under the government legislation provided benefits for only a portion of the services incurred.

2) The member's employer failed to obtain such coverage as required by law: this exclusion does not apply if the member's employer was not required and did not elect to be covered under any workers' compensation law; occupational disease law; or employer's liability act of any state, country, or the United States.

3) The member waived his or her rights to such coverage or benefits.

4) The member failed to file a claim within the filing period allowed by law for such benefits.

5) The member failed to comply with any other provision of the law to obtain such coverage or benefits.

6) The member was permitted to elect not to be covered by the workers' compensation law but failed to properly make such election effective. This exclusion does not apply if the member is permitted by statute not to be covered and elects not to be covered by a workers' compensation law; occupational disease law; or liability law.

If the member enters into a settlement giving up rights to recover past or future medical benefits under a workers' compensation law, the PEAK managed care option plan will not cover past or

future medical services that are the subject of (or related to) that settlement. In addition, if the member is covered by a workers' compensation program that limits benefits if providers other than those specified are used, and the member receives care or services from a provider not specified by the program, the PEAK managed care option plan will not cover the balance of any costs remaining after the program has paid.

c. Expenses Covered by Other Insurance Policies

Exclusions include expenses that a member is entitled to have covered (or that are paid) under an automobile insurance policy, a premise liability policy, or other liability insurance policy (such as a home owners or business liability policy). Exclusions also include expenses the member would be entitled to have covered under such policies if not covered by the PEAK managed care option plan, unless applicable law requires the PEAK managed care option plan to provide primary coverage.

2.13.21 CHARGES MEMBERS ARE NOT OBLIGATED TO PAY

Exclusions include services and supplies for which a member is not legally, or as a customary practice, required to pay in the absence of insurance or a hospital medical payment plan.

2.13.22 THIRD PARTY LIABILITY

Exclusions include services and supplies when another person or entity is legally responsible for causing or contributing to the condition which is being treated, and is therefore liable at law for the cost of treatment, unless the member complies with subrogation provisions of the Employer's Summary Plan Document.

2.13.23 UNUSUAL CIRCUMSTANCES

Neither the health plan nor any network or participating providers shall have any liability or obligation because of a delay or failure to provide covered medical services or benefits under the following circumstances:

a. complete or partial destruction of facilities;
b. war;
c. riot;
d. civil insurrection;
e. major disaster;
f. disability of a significant part of the participating hospital and/or provider network;
g. epidemic; or
h. labor dispute not involving the health plan, participating hospitals, and/or other participating providers.

Network providers will make their best efforts to provide services and benefits within the limitations of available facilities and personnel. If the rendering of covered medical services or benefits is delayed due to a labor dispute involving the health plan or network providers, non-emergency care may be deferred until after the resolution of the labor dispute.

2.13.24 VOCATIONAL REHABILITATION

2.13.25 DENTAL COVERAGE

Exclusions include dental coverage (see 2.12.3, for limited coverage due to accidental injury).

2.13.26 VISION SERVICES AND APPLIANCES

Exclusions include vision services and appliances including eye exams, glasses, contact lenses, radial keratomy or other surgery to correct vision, and orthoptic or vision training (These may be cvered by a separate employer vision plan).

2.13.27 TREATMENT FOR MALOCCLUSION OF THE JAW

Exclusions include services for temporomandibular joint dysfunction (TMJ), anterior or internal dislocations, derangements, myofascial pain syndrome, and orthodontics (dentofacial orthopedics) or related appliances except surgical treatment covered in 2.10.

2.13.28 ORGAN OR TISSUE TRANSPLANTS

Organ and tissue transplants are excluded, except as provided in 2.12.13.

2.13.29 SPEECH THERAPY

Developmental speech therapy is excluded from coverage except as covered in 2.12.11.

2.13.30 RESIDENTIAL CARE PROGRAMS FOR MENTAL ILLNESS TREATMENT

2.13.31 ANY ADDITIONAL CHARGES FOR INCLUSIVE PROCEDURES OR SERVICES

Exclusions include additional charges for inclusive

procedures or services.

2.13.32 SERVICES OR SUPPLIES NOT PROVIDED BY A LICENSED PROVIDER OR WHICH ARE NOT LISTED AS A BENEFIT IN THIS SUPPLEMENT

2.13.33 CHARGES RESULTING FROM LEAVING A HOSPITAL OR FACILITY CONTRARY TO MEDICAL ADVICE